ATHLETE OPHTHALMOLOGIC EXAM

Examinations will only be accepted if performed by a licensed physician/surgeon

_____/___/_____

First Middle Last Ring Name Telephone Date of Birth

_____

Address City State Zip code Country

HISTORY – Please provide the following information:

Name and hometown of your primary care physician:

_____

Has applicant ever had any of the following conditions:

1. Blurred vision? ˜ Yes ˜ No

2. Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye? ˜ Yes ˜ No

3. Has applicant had or been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract? ˜ Yes ˜ No If yes, please explain:_____

4. Eye Disease? ˜ Yes ˜ No List nature of diseases or injuries:_____

5. Eye Injury? ˜ Yes ˜ No List nature of diseases or injuries:_____

6. Retinal re-attachment? ˜ Yes ˜ No If yes, please explain:_____

7. Does the applicant have any other visual condition that would prevent him/her from safely engaging in boxing or martial arts activities? ˜ Yes ˜ No If yes, please explain: _____

EXAMINATION

VISION: Without / With Glasses REFRACTION: If either eye is 20/60 or worse:

Right _____/_____ Right ___ Sph___ Cyl x_____Acuity_____

Left _____/_____ Left ___ Sph___ Cyl x_____Acuity_____

Remarks: _____

Intraoccular Right_____mmHg _____

Tension Left _____mmHg_____
Motility Normal _____ Abnormal _____
Binocular Vision Normal _____ Abnormal _____

SLIT LAMP EXAM	**NORMAL**	**ABNORMAL**	**SPECIFYABNORMALITIES**
Conjunctiva	Right/Left	Right/Left	
Cornea_____	_____/____	_____/___	_____
Iris/Pupil_____ _	____/_____	___/_____	_____
Lens_____	___/___	_____/____	_____
Eyelids_____	___/_____	____/_____	_____

_

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

	NORMAL	**ABNORMAL**	**ABNORMALITIES**
	Right/Left	Right/Left	
Disc_____	___/___	___/___	_____
Macula_____	___/___	___/___	_____
Vessels_____	___/___	___/___	_____
Peripheral Retina_____	___/___	___/___	_____

PHYSICIAN'S REMARKS:
_____
_____
_____

Examining physician: Please mail a copy of any report, directly to the commission, for any applicant who has a condition that may preclude him/her from being licensed.

PHYSICIAN:
I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on the other side of this form.

I ☐ Do Not ☐ Do find any condition that would prevent the applicant from safely engaging in any boxing or martial arts activities as a

˜ professional boxer ˜ martial arts athlete

_____
Physician's Name and License Number

_____
Physician's Signature

_____ _____
Address Date

_____
City State Zip Code Telephone Number